

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13134  
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

13128

Reg. Dist. No.

|  |                                 |  |  |
|--|---------------------------------|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Worcester</u> MARYLAND  |                                 | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutional: Residence before admission)<br>a. STATE <u>Delaware</u> b. COUNTY <u>Worcester</u>    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabysville R.T.D.</u>   |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabysville R.T.D.</u>   |  |
| c. LENGTH OF STAY IN 1b <u>20 yrs.</u>   |                                 | d. STREET ADDRESS <u>1</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) First <u>Carrie</u> Middle <u>Griffin</u> Last <u>Cater</u>   |                                 | <b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>12</u> Year <u>1958</u>   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 1898</u>                   |
| 9. AGE (In years last birthday) <u>60</u> yrs.   |                                 | IF UNDER 1 YEAR Months Days Hours Min.   | IF UNDER 24 HRS. Months Days Hours Min.            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Portsmouth, Va.</u>   |                                 | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Sam Simpson</u>   |                                 | 14. MOTHER'S MAIDEN NAME <u>Martha Piddick</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                                 | 16. SOCIAL SECURITY NO. <u>—</u>   |  |
| 17. INFORMANT <u>Harold Cater</u> Address <u>Seabysville Del.</u>  |                                 |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>443X Congestive Heart Failure</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u><br>DUE TO (c) <u>Pneumonia</u> |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs</u><br><u>3 1/2 hrs</u><br><u>3 days</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>  |                                 | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                                 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>                          |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>5/2</u> , 19 <u>55</u> , to <u>11/12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/12</u> , 19 <u>58</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.   |                                 |  |  |
| ACTUAL SIGNATURE <u>Ivory U. Sully, Jr.</u> M.D.   |                                 | ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED <u>11/19/58</u>   |  |
| PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr. MD</u>  |                                 |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF               | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State)      |
| <u>Burial</u>  | <u>11/16/58</u>                 | <u>Annoneck Cem.</u>   | <u>New Annoneck Va.</u>                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>  |                                 | 24a. REC'D BY REGISTRAR DATE <u>NOV 18 '58</u>   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Friend</u> |

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

FILE NO.

DATE OF DEATH

AGE

SEX

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

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may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13135  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

13129

Reg. Dist. No.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Worcester</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Showell</u><br>c. LENGTH OF STAY IN 1b <u>Life</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>md</u><br>b. COUNTY <u>Worcester</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Showell Md</u><br>d. STREET ADDRESS <u>1</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) <u>James B Collins</u><br>First Middle Last   |   | 4. DATE OF DEATH<br>Month <u>Nov</u> Day <u>1</u> Year <u>1958</u>  |   |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>white</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>Apr 2-1884</u>  |
| 9. AGE (In years last birthday) <u>74</u> yrs.  |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Md</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |   |
| 13. FATHER'S NAME <u>Edward J Collins</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Mary Lockwood</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>X</u> (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT <u>Charlie F Collins</u>  |   | Address <u>Showell Md</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus c</u><br>DUE TO <u>150 X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Generalized metastasis</u><br>DUE TO <u>Cachexia &amp; inanition</u><br>(c) <u>1 mi</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1-2 yrs</u><br><u>6 mo.</u><br><u>1 mi</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>Nov</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1 Nov</u> , 19 <u>58</u> , and that death occurred at <u>11</u> A.M.; from the causes and on the date stated above.   |   |   |   |
| ACTUAL SIGNATURE <u>Harold Kaplan</u> M.D.  |   | ADDRESS (Street, city or town, state) <u>Berlin, Md</u>   |   |
| PHYSICIAN'S NAME (Type) <u>WATSON-GRAY</u>  |   | DATE <u>NOV 1 0 '58</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |   | 22b. DATE THEREOF <u>Nov 3 1958</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>   |   | 22d. LOCATION (City, town, or county) (State) <u>Bishopville Md</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>WATSON-GRAY</u>   |   | 24a. REC'D BY REGISTRAR <u>Arthur L. Kline</u>  |   |
| ADDRESS <u>Frankford Village</u>  |   | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>   |   |

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

|   |  |   |  |
|---|--|---|--|
| <p>1. NAME OF DECEASED</p>              |  | <p>2. SEX</p>                             |  |
| <p>3. AGE</p>                           |  | <p>4. DATE OF BIRTH</p>                   |  |
| <p>5. PLACE OF BIRTH</p>                |  | <p>6. DATE OF DEATH</p>                   |  |
| <p>7. TIME OF DEATH</p>                 |  | <p>8. CAUSE OF DEATH</p>                  |  |
| <p>9. MANNER OF DEATH</p>               |  | <p>10. SIGNATURE OF PHYSICIAN</p>         |  |
| <p>11. SIGNATURE OF REGISTRAR</p>       |  | <p>12. SIGNATURE OF WITNESS</p>           |  |
| <p>13. SIGNATURE OF DECEASED</p>        |  | <p>14. SIGNATURE OF NEXT OF KIN</p>       |  |
| <p>15. SIGNATURE OF BURIAL OFFICIAL</p> |  | <p>16. SIGNATURE OF FUNERAL HOME</p>      |  |
| <p>17. SIGNATURE OF CHURCH OFFICIAL</p> |  | <p>18. SIGNATURE OF CEMETERY OFFICIAL</p> |  |
| <p>19. SIGNATURE OF CORONER</p>         |  | <p>20. SIGNATURE OF JURY</p>              |  |
| <p>21. SIGNATURE OF JUDGE</p>           |  | <p>22. SIGNATURE OF CLERK</p>             |  |
| <p>23. SIGNATURE OF SHERIFF</p>         |  | <p>24. SIGNATURE OF DEPUTY SHERIFF</p>    |  |
| <p>25. SIGNATURE OF MARSHAL</p>         |  | <p>26. SIGNATURE OF CLERK OF COURT</p>    |  |
| <p>27. SIGNATURE OF JURY</p>            |  | <p>28. SIGNATURE OF JUDGE</p>             |  |
| <p>29. SIGNATURE OF CLERK</p>           |  | <p>30. SIGNATURE OF SHERIFF</p>           |  |
| <p>31. SIGNATURE OF DEPUTY SHERIFF</p>  |  | <p>32. SIGNATURE OF MARSHAL</p>           |  |
| <p>33. SIGNATURE OF CLERK OF COURT</p>  |  | <p>34. SIGNATURE OF JURY</p>              |  |
| <p>35. SIGNATURE OF JUDGE</p>           |  | <p>36. SIGNATURE OF CLERK</p>             |  |
| <p>37. SIGNATURE OF SHERIFF</p>         |  | <p>38. SIGNATURE OF DEPUTY SHERIFF</p>    |  |
| <p>39. SIGNATURE OF MARSHAL</p>         |  | <p>40. SIGNATURE OF CLERK OF COURT</p>    |  |
| <p>41. SIGNATURE OF JURY</p>            |  | <p>42. SIGNATURE OF JUDGE</p>             |  |
| <p>43. SIGNATURE OF CLERK</p>           |  | <p>44. SIGNATURE OF SHERIFF</p>           |  |
| <p>45. SIGNATURE OF DEPUTY SHERIFF</p>  |  | <p>46. SIGNATURE OF MARSHAL</p>           |  |
| <p>47. SIGNATURE OF CLERK OF COURT</p>  |  | <p>48. SIGNATURE OF JURY</p>              |  |
| <p>49. SIGNATURE OF JUDGE</p>           |  | <p>50. SIGNATURE OF CLERK</p>             |  |
| <p>51. SIGNATURE OF SHERIFF</p>         |  | <p>52. SIGNATURE OF DEPUTY SHERIFF</p>    |  |
| <p>53. SIGNATURE OF MARSHAL</p>         |  | <p>54. SIGNATURE OF CLERK OF COURT</p>    |  |
| <p>55. SIGNATURE OF JURY</p>            |  | <p>56. SIGNATURE OF JUDGE</p>             |  |
| <p>57. SIGNATURE OF CLERK</p>           |  | <p>58. SIGNATURE OF SHERIFF</p>           |  |
| <p>59. SIGNATURE OF DEPUTY SHERIFF</p>  |  | <p>60. SIGNATURE OF MARSHAL</p>           |  |
| <p>61. SIGNATURE OF CLERK OF COURT</p>  |  | <p>62. SIGNATURE OF JURY</p>              |  |
| <p>63. SIGNATURE OF JUDGE</p>           |  | <p>64. SIGNATURE OF CLERK</p>             |  |
| <p>65. SIGNATURE OF SHERIFF</p>         |  | <p>66. SIGNATURE OF DEPUTY SHERIFF</p>    |  |
| <p>67. SIGNATURE OF MARSHAL</p>         |  | <p>68. SIGNATURE OF CLERK OF COURT</p>    |  |
| <p>69. SIGNATURE OF JURY</p>            |  | <p>70. SIGNATURE OF JUDGE</p>             |  |
| <p>71. SIGNATURE OF CLERK</p>           |  | <p>72. SIGNATURE OF SHERIFF</p>           |  |
| <p>73. SIGNATURE OF DEPUTY SHERIFF</p>  |  | <p>74. SIGNATURE OF MARSHAL</p>           |  |
| <p>75. SIGNATURE OF CLERK OF COURT</p>  |  | <p>76. SIGNATURE OF JURY</p>              |  |
| <p>77. SIGNATURE OF JUDGE</p>           |  | <p>78. SIGNATURE OF CLERK</p>             |  |
| <p>79. SIGNATURE OF SHERIFF</p>         |  | <p>80. SIGNATURE OF DEPUTY SHERIFF</p>    |  |
| <p>81. SIGNATURE OF MARSHAL</p>         |  | <p>82. SIGNATURE OF CLERK OF COURT</p>    |  |
| <p>83. SIGNATURE OF JURY</p>            |  | <p>84. SIGNATURE OF JUDGE</p>             |  |
| <p>85. SIGNATURE OF CLERK</p>           |  | <p>86. SIGNATURE OF SHERIFF</p>           |  |
| <p>87. SIGNATURE OF DEPUTY SHERIFF</p>  |  | <p>88. SIGNATURE OF MARSHAL</p>           |  |
| <p>89. SIGNATURE OF CLERK OF COURT</p>  |  | <p>90. SIGNATURE OF JURY</p>              |  |
| <p>91. SIGNATURE OF JUDGE</p>           |  | <p>92. SIGNATURE OF CLERK</p>             |  |
| <p>93. SIGNATURE OF SHERIFF</p>         |  | <p>94. SIGNATURE OF DEPUTY SHERIFF</p>    |  |
| <p>95. SIGNATURE OF MARSHAL</p>         |  | <p>96. SIGNATURE OF CLERK OF COURT</p>    |  |
| <p>97. SIGNATURE OF JURY</p>            |  | <p>98. SIGNATURE OF JUDGE</p>             |  |
| <p>99. SIGNATURE OF CLERK</p>           |  | <p>100. SIGNATURE OF SHERIFF</p>          |  |

13136

CERTIFICATE OF DEATH

Reg. Dist. No.

13130

|   |                               |   |                                      |  |   |  |  |
|---|-------------------------------|---|--------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Worcester</i> MARYLAND  |                               |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Worcester</i> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Whaleyville</i>   |                               |   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Whaleyville</i>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                               |   |                                      | d. STREET ADDRESS <i>RFD.</i>  |   |  |  |
| 3. NAME OF DECEASED (Type or print) <i>Harold Lee Eshom</i>   |                               |   |                                      | 4. DATE OF DEATH <i>Nov. 18 1958</i>   |   |  |  |
| 5. SEX <i>Male</i>  | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>March 9 1919</i> | 9. AGE (In years last birthday) <i>39</i> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Former</i>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <i>own farm</i>   |                                      | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i>  |   | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>                             |  |
| 13. FATHER'S NAME <i>J. Selby Eshom</i>   |                               |   |                                      | 14. MOTHER'S MAIDEN NAME <i>Eva Kate Hudson</i>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <i>217-14 8630</i>  |                                      | 17. INFORMANT <i>Mrs Emma Eshom Whaleyville</i>  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>162.1</i> DUE TO <i>generalized metastatic Carcinoma</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Bronchiogenic Carcinoma</i><br>(c) <i>2 mos. 2-3 mos.</i> |                               |   |                                      | INTERVAL BETWEEN ONSET AND DEATH   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |   |                                      |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <i>19</i>  |                               |   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                    |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
|   |                               |   |                                      | 20f. (City or town) (County) (State)   |   |  |  |
| 21. I certify that I attended the deceased from <i>August</i> , 1958, to <i>November</i> , 1958, that I last saw the deceased alive on <i>Nov. 18</i> , 1958, and that death occurred at <i>8 A.</i> M., from the causes and on the date stated above.  |                               |   |                                      |  |   |  |  |
| ACTUAL SIGNATURE <i>Robert A. Grubb</i> M.D.  |                               |   |                                      | ADDRESS (Street, city or town, state) <i>BERLIN, Md.</i> DATE SIGNED <i>11/19/58</i>   |   |  |  |
| PHYSICIAN'S NAME (Type) <i>ROBERT A. GRUBB</i>  |                               |   |                                      |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>   |                               | 22b. DATE THEREOF <i>11/24/58</i>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY <i>Red Run</i>  |   | 22d. LOCATION (City, town, or county) (State) <i>Silkyville, Del.</i>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Peter Whaley Silkyville, Del.</i>   |                               |   |                                      | 24a. REC'D BY REGISTRAR <i>NOV 21 '58</i>  |   | 24b. REGISTRAR'S SIGNATURE <i>Carlton S. H.</i>                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





13137

## CERTIFICATE OF DEATH

13131

Reg. Dist. No.

|  |  |   |  |  |   |  |  |
|--|--|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Worcester</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Berlin Rural</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>all her life</b>   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Route # 3</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elsie</b> Middle <b>May</b> Last <b>Fassett</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>11</b> Day <b>19</b> Year <b>1958</b>   |   |  |  |
| 5. SEX<br><b>FM</b>  | 6. COLOR OR RACE<br><b>AA</b>          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 10, 1901</b>                                | 9. AGE (In years last birthday)<br><b>57 yrs.</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Factory</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Canning</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Charles E. Brittingham</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Jennie Robbins</b>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><b>213-24-2388</b>   |  | 17. INFORMANT<br><b>William W. Fassett, Berlin, Md., Route #3</b>  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>443X Congestive Heart Failure</b><br>DUE TO (b) <b>Hypertensive Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>3 yrs prior</b>              |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |  |  |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. <b>19</b>  | Month, Day, Year                       | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town)  | (County)                                  | (State)  |  |
| 21. I certify that I attended the deceased from <b>2/26</b> , 19 <b>55</b> , to <b>11/19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/19</b> , 19 <b>58</b> , and that death occurred at <b>3:50 P.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Berlin, Md.</b> DATE SIGNED <b>11/24/58</b> |  |   |  |  |   |  |  |
| ACTUAL SIGNATURE <b>Dr. I. V. Sully, M.D.</b>  |  | PHYSICIAN'S NAME (Type) <b>Dr. I. V. Sully, M.D.</b> <b>Berlin, Md., Route # 3</b>  |  |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>11-22-1958</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Germantown Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Berlin, Md.</b>  |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. F. Stewart Funeral Home, Salisbury, Md.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 28 '58</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Huns</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

13132

Reg. Dist. No.

13138

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>WORCESTER</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MD.</u> b. COUNTY <u>WORCESTER</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>NEWARK</u>   |  |   |  | c. LENGTH OF STAY IN 1b   |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>X NEWARK</u>                                     |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  |   |  | f. STREET ADDRESS<br><u>R.F.D. CEDARTOWN</u>  |  |   |   |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>GEORGE W. JOHNSON</u>   |  |   |  | 4. DATE OF DEATH Month Day Year<br><u>November 22, 1958</u>   |  |   |   |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>Colored</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>approx. 76</u> yrs.             | 9. AGE (In years lost birthday)<br><u>76</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.            | IF UNDER 24 HRS.<br>Hours Min.                |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FARMER</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Farm</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>NEWARK MD</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |   |
| 13. FATHER'S NAME<br><u>REUGEN R. JOHNSON</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>SARA LIZZIE JOHNSON</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u> <u>NO</u>  |  | 16. SOCIAL SECURITY NO.<br><u>NO</u>  |  | 17. INFORMANT Address<br><u>Mr. OTHO JOHNSON, NEWARK, MD.</u>   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u><br>DUE TO <u>Hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u><br>DUE TO (c) <u></u> |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)                                    | (County)  | (State)  |   |   |
| 21. I certify that I attended the deceased from <u>11-1</u> , 19 <u>58</u> , to <u>11-23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-23</u> , 19 <u>58</u> , and that death occurred at <u>6:15</u> P.M., from the causes and on the date stated above.  |  |   |  |   |  |   |   |
| ACTUAL SIGNATURE <u>Clifford E. Schott</u> M.D.   |  |   |  | ADDRESS (Street, city or town, state) <u>Berlin Md.</u>   |  |   |   |
| PHYSICIAN'S NAME (Type) <u>CLIFFORD E. SCHOTT</u>   |  |   |  | DATE SIGNED <u>BERLIN MD</u>  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 22b. DATE THEREOF<br><u>11/25/58</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>CEDAR CHAPEL</u>   | 22d. LOCATION (City, town, or county)<br><u>NEWARK</u> | (State)<br><u>MD.</u>   |  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>Anna D. Burbage Berlin Md</u>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>NOV 28 '58</u>   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Frank</u> |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

Reg. Dist. No.

NAME OF DECEASED

SEX

DATE OF DEATH

AGE

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

DISSEMINATED

INTERMITTENT

CHRONIC

ACUTE

SYMPTOMS

DIAGNOSIS

TREATMENT

PROGNOSIS

PATHOLOGICAL FINDINGS

LABORATORY TESTS

POST-MORTEM

REPORT

SIGNATURE

DATE

PLACE

REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13139

## CERTIFICATE OF DEATH

13133

Reg. Dist. No.

|  |                               |  |                                      |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>            |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>  |                               | c. LENGTH OF STAY IN 1b  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> 0913.2   |                                      |
|  |                               | d. STREET ADDRESS <u>4 Peachblossom St.</u>  |                                      |
|  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print) <u>Melvin</u> First <u>Jones</u> Middle <u>Jones</u> Last  |                               | 4. DATE OF DEATH <u>Nov.</u> Month <u>10</u> Day <u>1958</u> Year  |                                      |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 3, 1920</u> |
| 9. AGE (In years last birthday) <u>38</u> yrs.   |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Wire Cloth Belts</u>  |                                      |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>  |                                      |
| 13. FATHER'S NAME <u>James Jones</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>U S Army</u> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <u>Unknown</u>   |                                      |
| 17. INFORMANT <u>Mrs Melvin Jones</u> Address <u>Cambridge Maryland</u>  |                               |  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u><br>DUE TO (c)         |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>1/2 year</u><br><u>5 yrs</u>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <u>11/10/58</u> , 19 <u>58</u> , to <u>11/10/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/10/58</u> , 19 <u>58</u> , and that death occurred at <u>12:45 P</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED |                               |  |                                      |
| ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.  |                               | <u>11-11-58</u>  |                                      |
| PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, M. D.</u>   |                               | <u>Bay St., Snow Hill, Md.</u>   |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 22b. DATE THEREOF <u>Nov. 12, 1958</u>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Men. Park</u>   |                               | 22d. LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u> ADDRESS <u>Cambridge Maryland</u>   |                               | 24a. REC'D BY REGISTRAR <u>NOV 14 58</u> DATE  |                                      |
|  |                               | 24b. REGISTRAR'S SIGNATURE <u>Carroll L. Pender</u>  |                                      |

CERTIFICATE OF DEATH

1918



Blank certificate form with horizontal lines for text entry.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13140

CERTIFICATE OF DEATH

13134

Reg. Dist. No.....

|   |                                |  |   |   |   |  |                                |
|---|--------------------------------|--|---|---|---|--|--------------------------------|
| 1. PLACE OF DEATH   |                                |  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED   |   |  |                                |
| COUNTY <u>Worcester</u>   |                                | MARYLAND   |   | STATE <u> Md. </u>  |   | COUNTY <u> Worcester </u>  |                                |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Berlin</u>   |                                | LENGTH OF STAY (in this place)<br><u>72 yrs</u>  |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Berlin</u> |   |  |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>Flower St Home</u>  |                                |  |   | STREET ADDRESS (If rural give location)<br><u>Flower Street</u>                             |   |  |                                |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)<br><u>Laura C. Pitts</u>  |                                |  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>November 20, 58</u>                             |   |  |                                |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>Col</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>W</u>   | 8. DATE OF BIRTH<br><u>May 27, 1886</u> | 9. AGE last birthday<br><u>72</u> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Domestic</u>  |                                | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                         |                                |
| 13. FATHER'S NAME<br><u>Charles Brittingham</u>   |                                |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Maggie PURNELL</u>   |   |  |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br><u>no</u>  |                                | 16. SOCIAL SECURITY NO.<br><u>915</u>  |   | 17. INFORMANT & ADDRESS<br><u>Clara Purnell RFD #3 Box 113 Berlin, Md</u>                   |   |  |                                |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                |  |   | 18. MEDICAL CERTIFICATION   |   |  |                                |
| IMMEDIATE CAUSE (A)<br><u>443X</u>  |                                |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u>   |   |  |                                |
| ANTECEDENT CAUSE(S) DUE TO (B)<br><u>Hypertensive Cardio-vascular Disease</u>   |                                |  |   | <u>4 1/2 yrs.</u>   |   |  |                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)  |                                |  |   |   |   |  |                                |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                |  |   |   |   |  |                                |
| 19a. DATE OF OPERATION  |                                | 19b. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |  |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)                                 |   | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                |   |  |                                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.  |                                | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?  |   |  |                                |
| 22. I hereby certify that I attended the deceased from <u>4/8, 1957</u> , to <u>11/15, 1958</u> , that I last saw the deceased alive on <u>11/15, 1958</u> , and that death occurred at <u>12:00 A.M.</u> from the causes and on the date stated above. |                                |  |   |   |   |  |                                |
| SIGNATURE<br><u>Loony V. Shuler, Jr.</u> M.D.   |                                |  |   | ADDRESS (Street, city, town, state)<br><u>Flower Street Berlin, Md</u>                      |   | DATE SIGNED<br><u>11/22/58</u>                                     |                                |
| 23. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                | DATE THEREOF<br><u>11/22/1958</u>  |   | NAME OF CEMETERY OR CREMATORY<br><u>Evergreen</u>   |   | LOCATION (City, town, or county) (State)<br><u>Berlin Maryland</u> |                                |
| 24. REC'D BY REGISTRAR<br>DATE <u>NOV 28 '58</u>  |                                | REGISTRAR'S SIGNATURE<br><u>Arthur E. Cross</u>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Clinton F. Stewart</u> ADDRESS<br><u>Salis Md.</u>   |   |  |                                |

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Form One 1915

1. NAME OF DECEASED

LAST

FIRST

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MEDICAL OPINION

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF BURIAL OFFICER

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF CONSTABLE

24. SIGNATURE OF TOWNSHIP CLERK

25. SIGNATURE OF COUNTY CLERK

26. SIGNATURE OF STATE CLERK

27. SIGNATURE OF SECRETARY

28. SIGNATURE OF ASSISTANT SECRETARY

29. SIGNATURE OF CHIEF CLERK

30. SIGNATURE OF DEPUTY CHIEF CLERK

INSTRUCTIONS

1. This form is to be filled out by the physician or other person who has attended the deceased, or by the coroner, or by the registrar, or by the witnesses, or by the deceased, or by the next of kin, or by the clergyman, or by the burial officer, or by the interviewer, or by the coroner, or by the jury, or by the judge, or by the sheriff, or by the constable, or by the township clerk, or by the county clerk, or by the state clerk, or by the secretary, or by the assistant secretary, or by the chief clerk, or by the deputy chief clerk.



13133

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                     |  |   |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Worcester</b> MARYLAND  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pocomoke City</b>  |                                     | c. LENGTH OF STAY IN 1b<br><b>85 years</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>220 Walnut Street</b>  |                                     | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ESTELLE</b> Middle <b>E.</b> Last <b>POWELL</b>   |                                     | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>4</b> Year <b>19 58</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>January 3, 1873</b>                                      |
| 9. AGE (In years last birthday)<br><b>85 yrs.</b>   |                                     | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Frank J. Ross</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Sarah M. Powell</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                     | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| 17. INFORMANT<br><b>Mrs William Trader, Pocomoke City, Md.</b>  |                                     | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br><b>592x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Nephritis</b><br>DUE TO<br>(c)  |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>years</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>4 Bronchiectasis 2. Degenerative Heart Disease</b>  |                                     | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>Feb. 19 49</b> , to <b>Nov. 4, 19 58</b> , that I last saw the deceased alive on <b>Nov. 4, 19 58</b> , and that death occurred at <b>3:45 a. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Charles W. Trader, M.D. 302 Market St., Pocomoke City, Md. 11-5-58</b> |                                     |  |   |
| ACTUAL SIGNATURE<br><b>Charles W. Trader, M.D.</b>  |                                     |  |   |
| PHYSICIAN'S NAME (Type)<br><b>Charles W. Trader, M.D.</b>   |                                     |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>11-6-58</b> | 22c. NAME OF CEMETERY<br><b>Bethany Methodist</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Pocomoke City, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Henry J. Watson</b>  |                                     | ADDRESS<br><b>Pocomoke City, Md.</b>   |   |
| 24a. REC'D BY REGISTRAR<br><b>NOV 7 '58</b>   |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Charles L. King</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

13141 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13136

Reg. Dist. No.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WORCESTER</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Wor</u>   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Ocean City</u>   |  | c. LENGTH OF STAY IN 1b<br><u>60 years</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>x RI Ocean City, Md.</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  |  |  | d. STREET ADDRESS<br><u>1</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Edwin</u> Middle <u>Delroy</u> Last <u>Taylor</u>   |  |  |  | 4. DATE OF DEATH<br>Month <u>Nov</u> Day <u>30</u> Year <u>1958</u>  |  |   |  |
| 5. SEX<br><u>M</u>  |  | 6. COLOR OR RACE<br><u>W</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                |  | 8. DATE OF BIRTH<br><u>May 7, 1898</u>  |  |
| 9. AGE (In years last birthday)<br><u>60</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>   |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Salesman/HK</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Retail</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Ocean City, Md.</u>                               |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |  |  |  |  |   |  |
| 13. FATHER'S NAME<br><u>L. HAZZARD Taylor</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Angeline BAKER</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>YES</u> <u>WWI</u>   |  |  |  | 16. SOCIAL SECURITY NO.<br><u>216-09-7786</u>  |  | 17. INFORMANT<br>Address <u>MRS ANNA Burbage Berlin, Md.</u>                                      |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY Occlusion, Acute</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic CVI</u><br>DUE TO (c) <u>  </u>   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Instant.</u><br><u>8 years.</u>                            |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x1 Diabetes mellitus</u> <u>Gout.</u>   |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u><br>Month, Day, Year <u>19</u>   |  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br><u>F J Townsend</u>   |  |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |   |  |
| EXAMINER'S NAME (Type)<br><u>F J TOWNSEND JR</u>  |  |  |  | DATE SIGNED<br><u>DEC 1, 58</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  | 22b. DATE THEREOF<br><u>12/2/58</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>EVERGREEN</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>BERLIN MD</u>                                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Anna A. Burbage</u>  |  |  |  | ADDRESS<br><u>Berlin Md.</u>   |  | 24a. REC'D BY REGISTRAR<br><u>DEC 2 58</u>  |  |
|   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hines</u>   |  |   |  |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |                                  |  |                               |  |
|--|--|----------------------------------|--|-------------------------------|--|
| NAME OF DECEASED<br>_____              |  | SEX<br>_____                     |  | AGE<br>_____                  |  |
| PLACE OF BIRTH<br>_____                |  | OCCUPATION<br>_____              |  | DATE OF DEATH<br>_____        |  |
| PLACE OF DEATH<br>_____                |  | TIME OF DEATH<br>_____           |  | CAUSE OF DEATH<br>_____       |  |
| MANNER OF DEATH<br>_____               |  | MEDICAL HISTORY<br>_____         |  | PHYSICAL EXAMINATION<br>_____ |  |
| TOXICOLOGICAL HISTORY<br>_____         |  | POST-MORTEM EXAMINATION<br>_____ |  | OTHER INFORMATION<br>_____    |  |
| SIGNATURE OF MEDICAL EXAMINER<br>_____ |  | SIGNATURE OF WITNESS<br>_____    |  | SIGNATURE OF CORONER<br>_____ |  |
| TITLE OF MEDICAL EXAMINER<br>_____     |  | TITLE OF WITNESS<br>_____        |  | TITLE OF CORONER<br>_____     |  |

1

## CERTIFICATE OF DEATH

Reg. Dist. No.

13142

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>           |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>  |  |  |  | c. LENGTH OF STAY IN 1b <u>7 mos</u>   |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>500 Philadelphia Ave</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>D.</u> Last <u>TULL</u>   |  |  |  | 4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1958</u>  |  |  |   |
| 5. SEX <u>F</u>   |  | 6. COLOR OR RACE <u>AA</u>             |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>MAY 23, 1867</u>                                   |   |
| 9. AGE (In years last birthday) <u>91</u> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS. Months Days Hours Min.  |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>              |   |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |  |  |  |  |   |
| 13. FATHER'S NAME <u>HENRY DASHIELL</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>PRISCILLA WART</u>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO. <u>218-24-5151</u>   |  |  |   |
| 17. INFORMANT <u>JACK SMACK</u> Address <u>500 Phila. Ave, Ocean City, Md</u>   |  |  |  |  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia</u><br><u>442x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Cardio renal disease</u><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 yr</u><br><u>5 yrs</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
| 20f. (City or town) _____ (County) _____ (State) _____  |  |  |  |  |  |  |   |
| 21. I certify that I attended the deceased from <u>Sept 19 22</u> to <u>Nov 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>30 Mar</u> , 19 <u>58</u> , and that death occurred at <u>4:40 P.M.</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Ocean City, Md</u> DATE SIGNED <u>27 Nov 58</u>  |  |  |  |  |  |  |   |
| ACTUAL SIGNATURE <u>J. D. Thomas</u> M.D.   |  |  |  |  |  |  |   |
| PHYSICIAN'S NAME (Type) <u>J. D. Thomas</u>   |  |  |  |  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 22b. DATE THEREOF <u>11-28-58</u>      |  | 22c. NAME OF CEMETERY OR CREMATORY <u>EBENEZER CEMETERY</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>     |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Stewart</u> ADDRESS <u>FUNERAL HOME, Salisbury, Md</u>  |  |  |  | 24a. REC'D BY REGISTRAR <u>DEC 3 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>                     |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13143 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13138

Reg. Dist. No.

|   |                                  |   |  |  |  |   |   |
|---|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Worcester</b> <span style="float: right;">MARYLAND</span>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>       |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Pocomoke City</b>  |                                  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><input checked="" type="checkbox"/> <b>Rural Pocomoke City</b> |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |                                  |   |  | d. STREET ADDRESS  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROY</b> Middle <b>LEE</b> Last <b>WARD</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>21</b> Year <b>19 58</b>  |  |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 15, 1958</b> |  | 9. AGE (In years last birthday)<br>yrs. <b>6</b> | IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>8</b> Hours <b>Min.</b>                                |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>---  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br>---  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Thomas E. Ward</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Susan Jane Tarr</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>---   |                                  | 16. SOCIAL SECURITY NO.<br>---  |  | 17. INFORMANT<br>Address<br><b>Thomas E. Ward, Pocomoke City, Maryland</b>   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxia</b><br>DUE TO <b>Suffocation in bed</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Suffocation in bed</b><br>DUE TO (c) <b>Suffocation in bed</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>Short</b>                                 |                                  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |  |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Suffocated</b>   |  |  |  |   |   |
| 20c. TIME OF INJURY<br>Hour <b>10:30</b> p. m. Month, Day, Year <b>11 21 19 58</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>  |  | 20f. (City or town) <b>Worcester</b> (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                                  |   |  |  |  |   |   |
| ACTUAL SIGNATURE<br><b>N. E. Sartorius Sr.</b>  |                                  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                       |   |
| EXAMINER'S NAME (Type)<br><b>N. E. SARTORIUS, SR.</b>   |                                  | DATE SIGNED<br><b>11/21/58</b>  |  |  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>11-22-58</b>  |  | 22c. NAME OF CEMETERY<br><b>Beth Eden Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Rural Pocomoke City, Md.</b>                  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Henry S. Stinson</b>   |                                  |   |  | ADDRESS<br><b>Pocomoke City, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>NOV 24 '58</b>  |   |
|   |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>William S. Kraus</b>  |  |   |   |

2082263XV6

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Department of Health, Bureau of Medical Examiners, Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                        |  |                      |  |                               |  |                        |  |                       |  |
|------------------------|--|----------------------|--|-------------------------------|--|------------------------|--|-----------------------|--|
| Name of Deceased       |  | Sex                  |  | Age                           |  | Date of Death          |  | Place of Death        |  |
| John Doe               |  | Male                 |  | 45                            |  | Nov. 15, 1935          |  | New York City         |  |
| Cause of Death         |  | Manner of Death      |  | Occupation                    |  | Residence              |  | Signature of Examiner |  |
| Heart Disease          |  | Natural              |  | Physician                     |  | 123 Main St.           |  | [Signature]           |  |
| Disease or Injury      |  | Cause of Injury      |  | Time of Death                 |  | Place of Burial        |  | Signature of Coroner  |  |
| Myocardial Infarction  |  | None                 |  | 11:00 AM                      |  | Cemetery               |  | [Signature]           |  |
| Signature of Physician |  | Signature of Coroner |  | Signature of Medical Examiner |  | Signature of Registrar |  | Signature of Clerk    |  |
| [Signature]            |  | [Signature]          |  | [Signature]                   |  | [Signature]            |  | [Signature]           |  |